State of Nebraska
Department of Health and Human Services
Credentialing Division
P O Box 94986
301 Centennial Mall South
Lincoln, NE 68509-4986
(402) 471-2118

CERTIFICATE OF POST-GRADUATE MEDICAL EDUCATION

Applicants must have the **current Program Director** of the institution where they completed their post-graduate medical education complete the following form and **affix the Official School Seal**. An **original** signature from the Program Director is required. Please mail the form directly to the address printed above.

Print Name _____ **SS#** _____

NOTE: The information below must be completed ONLY by an official of the program/facility.
NOT TO BE COMPLETED BY APPLICANT

It is hereby certified that: _____
(Name of Applicant)

Has successfully completed _____
(Name of Residency/Internship/Fellowship)

located at : _____ **in** _____
(Name of Hospital/Teaching Institution) (City, State, Country)

From _____ **To** _____
(Month/Day/Year) (Month/Day/Year)

At the time this applicant was enrolled in this Program, this Program was:

_____ **ACGME* or AOA* accredited**
*ACGME - Accreditation Council for Graduate Medical Education
*AOA – American Osteopathic Association

_____ **RCPSC* or CFPC* accredited**
*RCPSC – Royal College of Physicians and Surgeons of Canada
*CFPC – College of Family Physicians of Canada

_____ **was not accredited by any of the above listed entities**

Any Disciplinary Action? Yes _____ No _____ If yes, provide details of the disciplinary action.

Any Derogatory Information on File? Yes _____ No_____ If yes, provide details of the derogatory information.

Signature _____
Signature of CURRENT PROGRAM DIRECTOR
(Signature stamp **NOT** acceptable)

Print Name_____

Title _____

Date (month/day/year) _____

Phone # _____

Fax # _____

E-mail _____

INSTITUTIONAL SEAL

(If your institution does not have an official seal, this form must be notarized)